Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
CITY OF DALLAS

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-09-9375-01

MFDR Date Received
JUNE 12, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "If calculated pursuant to section 134.403(f)(1)(A), reimbursement for the services provided should be $14,385.34… Therefore, the Carrier is required to reimburse Vista Hospital of Dallas $14,385.34 pursuant to the Outpatient Fee Guideline, which will result I fair and reasonable reimbursement for the services provided to the injured worker. The Carrier made a partial payment of $3,135.33. Therefore, the Carrier is required to reimburse Provider in the additional amount of $11,250.01, plus any and all applicable interest."

Amount in Dispute: $11,250.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "At the outset it should be noted that the Provider has been paid $3,135.33 for this date of service. Check # 95640 was issued to the Provider on July 28, 2008. The Requestor is mistaken when it states in the DWC-60 that nothing has been paid… Per Rule 133.200, carriers cannot change procedure codes listed in a medical bill. This bill was properly returned to the Requestor per Rule 133.200. The Self-Insured will re-audit the clean claim upon submission."

Response Submitted by: Harris & Harris, PO Box 91569, Austin, TX 78709

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2008	Outpatient Hospital Services	$11,250.01	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the

reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 24, 2008
   - 222 – Charge exceeds Fee Schedule allowance.
   - 272 – By report code. Please resubmit documentation to support billed charges.
   - 785 – Items and/or services are packaged into APC rate. Therefore there is no separate APC payment.
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 97 – Payment is included in the allowance for another service/procedure.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 272 – By report code. Please resubmit documentation to support billed charges and 16 – Claim/service lacks information which is needed for adjudication. Review of the documentation submitted by the Carrier does not support the denial codes/reasons. Therefore, the disputed dates of service will be review in accordance with Division rules and the Texas Labor Code.
2. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Per Medicare policy, procedure code A4649 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
   - Per Medicare policy, procedure code A4649 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
   - Procedure code 25116 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 49, which, per OPPS Addendum A, has a payment rate of $1,354.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $812.82. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted

labor-related amount of $795.43. The non-labor related portion is 40% of the APC rate or $541.88. The sum of the labor and non-labor related amounts is $1,337.31. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $0.00 yields a cost of $0.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $1,337.31 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $1,922.15. The allocated portion of packaged costs is $1,922.15. This amount added to the service cost yields a total cost of $1,922.15. The cost of this service exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers and any multiple procedure discount, is $1,337.31. This amount multiplied by 200% yields a MAR of $2,674.61.

- Per Medicare policy, procedure code 25295 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
- Procedure code 99144 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Per Medicare policy, procedure code 94762 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
- Per Medicare policy, procedure code 94760 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
- Per Medicare policy, procedure code 99205 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
- Per Medicare policy, procedure code 99234 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.

5. The total recommended payment for the services in dispute is $2,674.61. This amount less the amount previously paid by the insurance carrier of $3,135.33 leaves an amount due to the requestor of $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 14, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.